PREMIER ACCESS (PPO) PLAN

BENEFIT	COST SHARING	
	IN-NETWORK	OUT-OF-NETWORK
Deductible	Single $400 / $1000 / $1500 Family $800 / $2000 / $3000	Single $700 / $1500 / $2250 Family $1400/ $3000/ $4500
Maximum Out-of-Pocket for Covered Expenses After Deductible	Single $1500 / $2500 / $4000 Family $3000 / $5000 / $8000	Single $2500 / $4000 / $5000 Family $5000 / $8000 / $10000
Co-insurance	As Indicated Deductible Applies*	As Indicated Deductible Applies*
Lifetime Maximum Benefit	Unlimited for $400/$800 deductible plan For all other deductible plans: $2 million limit for In-Network and Out-of-Network benefits combined	Unlimited for $700/$1400 deductible For all other deductible plans: $2 million limit for In-Network and Out-of-Network benefits combined
In-Hospital Care - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	15% Co-insurance - No Deductible	35% Co-insurance*
Ambulatory/Hospital Outpatient Surgery	20% Co-insurance*	40% Co-insurance*
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, and Small Bowel)	15% Co-insurance - No Deductible	35% Co-insurance*
Out-Patient Services - Provider Office Visit, Office Diagnostic and Allergy Testing, Allergy Serum and Injections, Diabetes Education and Therapy, Radiation, Chemotherapy, and Dialysis	$10 Co-payment (includes all services provided during the office visit) 20% Co-insurance* (for services not provided during the office visit)	40% Co-insurance*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered Same as Spouse Pregnancy)	$10 Co-payment for Office Visit in Which Pregnancy is Diagnosed 15% Co-insurance* for Hospitalization (See Bulleted Notes Below)	35% Co-insurance*
Emergency Services - Hospital Emergency Room (Co-insurance Waived if Admitted) & Ground Only Ambulance	20% Co-insurance*	20% Co-insurance*
Urgent Care Treatment	$25 Co-payment	30% Co-insurance*
Preventive Services: Immunizations	Either included in the Office Visit $10 Co-payment or 20% Co-insurance* for all services not provided during office visit	Preventive Services Are Not Covered Out-of-Network
Well Child and Adolescent Care (0-18 years) - Age and Periodicity Limits May Apply	$10 Co-payment per Office Visit	
Well Adult Care- Age and Periodicity Limits May Apply	$10 Co-payment for Routine Physical Exam and Specified Testing	
Mental Health: Inpatient	20% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)	40% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)
Outpatient	20% Co-insurance*, 20 visits per Plan Year	40% Co-insurance*, 20 visits per Plan Year
Autism - $500 Monthly Benefit for Children Ages 2 through 21 Years of Age for Therapeutic, Respite and Rehabilitative Care	Co-insurance Applicable to Service Provided*	Co-insurance Applicable to Service Provided*

*Deductible Applies

PREMIER ACCESS (PPO) PLAN (Cont'd)

BENEFIT	COST SHARING	
	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse: Inpatient Outpatient	 20% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) 20% Co-insurance*, 20 visits per Plan Year	 40% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis) 40% Co-insurance*, 20 visits per Plan Year
Prescription Drugs and Oral Contraceptives Mail Order Service Pharmacy	20% Co-insurance* - 30 day supply (Co-insurance Amount Does Not Apply Toward Satisfaction of Maximum Out-of-Pocket limit.) 20% Co-insurance* - 90 day supply	40% Co-insurance* - 30 day supply (Co-insurance Amount Does Not Apply Toward Satisfaction of Maximum Out-of-Pocket limit.) Not Covered Out-of-Network
Physical Therapy	20% Co-insurance* 30 visits per Plan Year	40% Co-insurance* 30 visits per Plan Year
Occupational Therapy	20% Co-insurance* 30 visits per Plan Year	40% Co-insurance* 30 visits per Plan Year
Speech Therapy	20% Co-insurance* 30 visits per Plan Year	40% Co-insurance* 30 visits per Plan Year
Cardiac Rehabilitation Therapy	20% Co-insurance* 30 visits per Plan Year	40% Co-insurance* 30 visits per Plan Year
Osteopathic/Chiropractic Manipulative Treatment	20% Co-insurance* 20 visits per Plan Year	40% Co-insurance* 20 visits per Plan Year
Home Health Care	100 Visits Per Plan Year Covered in Full*	100 Visits Per Plan Year - 20% Co-insurance*
Skilled Nursing Facility	20% Co-insurance* 30 Days per Plan Year	40% Co-insurance* 30 Days per Plan Year
DME/Prosthetic Devices/Hearing Aids	20% Co-insurance*	40% Co-insurance*
Hospice	Covered in Full	Covered in Full

*Deductible Applies.

- The single and family deductible amounts may be either:
    - A combined deductible for both medical and pharmacy services; or
    - A split deductible with a set amount for medical services and for pharmacy services.
- PPO is an acronym for a "preferred provider organization" product.
- PPO out-of-network coverage is limited to usual, reasonable and customary charges.
- PPO out-of-network coverage for preventive services is not available.
- PPO out-of-network coverage for transplants, substance abuse and mental health services is subject to Pre-certification.
- PPO in-network coverage for maternity care – the initial office visit in which pregnancy is diagnosed is subject to the provider office visit co-payment. No additional co-payments are applied to prenatal visits. All other in-network maternity expenses are subject to the deductible and Co-insurance except as noted in the following comment.
- PPO in-network deductible does not apply to hospitalization.

*Deductible Applies